STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395164	A. BLDG: 00 B. WING:	06/16/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. JOHN SPECIALTY CARE CTR STATE LICENSE NUMBER: 970802	P O BOX 928 500 WITTENBERG WAY MARS, PA 16046

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, and State Licensure Survey completed on June 16, 2023, it was determined that St. John Specialty Care Center, was not in compliance with the requirements of 42 CFR part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0656 SS=E		F 0656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0656 SS=E	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. The care plan for resident R9 was updated to reflect their diagnosis. The care plan for resident R35 was updated to reflect oxygen use. The care plan for resident R148 was updated to reflect oxygen care and usage. Resident R246 discharged on 6/29/2023. 2. Nurses notes will be monitored each business day during clinical report beginning 6/28/23 and will continue ongoing. Any residents with new diagnoses or treatments will be discussed and care plans reviewed to determine if additional interventions are needed. 3. Audit of current residents will be completed by 7/21/2023 to identify those using oxygen and to ensure careplans reflect diagnosis and physician orders. 4. New admission care plans will be audited by day 5 to ensure diagnoses and physician orders are care planned. 5. DON or designee will educate RNACs and clinical managers on the importance of documenting new diagnoses and orders and updating	Completion Date: **07/28/2023** Status: **APPROVED** Date: **07/10/2023**

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F 0656 SS=E	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	the careplan to reflect the updated by 7/7/2023. 6. Education and audits will be reviewed at the quarterly Quality Assurance and Performance Improvement meetings.	

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F 0656 SS=E	Continued from page 3 Based on a review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for four of 16 Residents (Resident R9, R35, R148 and R246). Findings include: Review of the facility policy "Comprehensive Care Plan Completion" dated 8/31/22, indicated the facility will develop a comprehensive plan of care for each resident, and that each triggered Care Assessment Area (CAA) must be assessed to facilitate care plan decision making. Review of the clinical record indicated Resident R9 was admitted to the facility on 12/9/11. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 6/5/23, included diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder	F 0656		

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F 0656 SS=E	Continued from page 4 symptoms), bipolar disorder (a mental condition marked by alternating periods of elation and depression), and post-traumatic stress disorder (PTSD, mental health condition triggered by experiencing or witnessing a terrifying event. Review of Resident R9's care plan, updated 2/21/23, did not identify Resident R9's PTSD diagnosis, symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. Review of the clinical record indicated Resident R35 was admitted to the facility on 5/27/23. Review of the MDS dated 6/8/23, indicated diagnoses of pneumonia (severe inflammation of the lungs from an infection), bronchitis (inflammation of the lining of the tubes that carry air to and from the lungs), and respiratory failure (a serious condition where the lungs cannot get enough oxygen into the blood).	F 0656		

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F 0656 SS=E	Continued from page 5 Observation and interview of Resident R35 on 6/14/23, revealed the resident was receiving oxygen at three liters per minute via a nasal cannula (an oxygen delivery device consisting of a lightweight tube which on one end splits into two prongs which are placed in the nostrils). Review of Resident R35's care plan last reviewed 5/30/23, failed to include a plan of care related to the use of oxygen therapy. Review of the clinical record indicated Resident R148 was admitted to the facility on 6/9/23. Review of the MDS dated 6/12/23, indicated diagnoses of pneumonia (severe inflammation of the lungs from an infection), respiratory failure (a serious condition where the lungs cannot get enough oxygen into the blood), and dependence on supplemental oxygen. Review of physician's orders indicated current	F 0656		

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F 0656 SS=E	Continued from page 6 orders to titrate oxygen to maintain oxygen saturation (the amount of oxygen present in the blood) above 90%. Observation and interview of Resident R148 on 6/12/23, revealed the resident was receiving oxygen at 3 liters per minute via nasal cannula. Review of Resident R148's care plan last reviewed 6/12/23, failed to include a plan of care related to the use of oxygen therapy. During an interview on 6/16/23, at 11:03 a.m. the Director of Nursing (DON) confirmed the facility failed to develop comprehensive care plans to meet resident care needs for Residents R35 and R148. Review of clinical record indicated that Resident R246 was admitted to the facility on 6/7/23. Review of the MDS dated 6/15/23, indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the	F 0656		

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F 0656 SS=E	Continued from page 7 brain), hypertension (high blood pressure in the arteries), and dysphagia (difficulty swallowing). Review of physician order dated 6/7/23, revealed that Resident R246 is to be NPO (receive nothing by mouth). Review of Resident R246's nutrition care plan revealed interventions that included honoring food preferences, monitoring oral intake of food and fluid, and providing necessary assistance at mealtime and between meals. During an interview on 6/16/23, at 12:02 p.m. the DON confirmed that the facility failed to develop a comprehensive care plan to meet resident care needs of four of 16 residents. 28 Pa. Code: 211.11(a)(b)(c)(d) Resident care plan.	F 0656		

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F 0695 SS=E	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident R35 has an updated order for oxygen and oxygen tubing changes. The oxygen tubing and equipment for R148. An order for oxygen tubing and nebulizer equipment changes every 2 weeks was added for residents R148. R152 was discharged on 6/21/23. 2. Nurses notes will be monitored each business day during clinical report. Any residents with new respiratory diagnoses or treatments will be discussed and orders reviewed to ensure equipment changes are entered beginning 6/28/23 and will continue ongoing. 3. Residents who receive oxygen therapy or respiratory care will have their orders audited by 7/14/2023 to ensure orders for equipment changes are entered. Resident equipment will be audited weekly for x4 weeks then biweekly ongoing to ensure that they are being stored properly and changed timely. 4. DON or designee will educate nursing staff on proper storage of oxygen equipment by 7/14/23. 5. Education and audits will be reviewed at the quarterly Quality Assurance and Performance Improvement meetings	Completion Date: **07/28/2023** Status: **APPROVED** Date: **07/10/2023**

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F 0695 SS=E	Continued from page 9 Based on review of facility policies, resident observations and interviews, clinical record review, and staff interviews, it was determined that the facility failed to provide appropriate respiratory care for three of five residents (Residents R35, R148, and R152). Findings include: Review of the facility's policy "Oxygen Via Concentrator" dated 8/31/2022, indicated the facility will verify physician orders for oxygen therapy and that oxygen tubing will be changed every 2 weeks and as needed. Review of the clinical record indicated Resident R35 was admitted to the facility on 5/27/23. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 6/8/23, indicated diagnoses of pneumonia (severe inflammation of the lungs from an infection), bronchitis (inflammation of	F 0695		

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F 0695 SS=E	Continued from page 10 the lining of the tubes that carry air to and from the lungs), and respiratory failure (a serious condition where the lungs cannot get enough oxygen into the blood). Observation and interview of Resident R35 on 6/14/23, at 11:09 a.m. revealed the resident was receiving oxygen at 3 liters per minute via a nasal cannula (an oxygen delivery device consisting of a lightweight tube which on one end splits into two prongs which are placed in the nostrils). Review of the clinical record failed to reveal a current physician order for Resident R35 to receive oxygen therapy and a current order to change oxygen tubing per facility policy. During an interview on 6/16/23, at 10:35 a.m. the Assistant Director of Nursing (ADON) confirmed there was no order for oxygen therapy and no order to change oxygen tubing per facility policy. Review of the facility's policy "Oral Inhalation and	F 0695		

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F 0695 SS=E	Continued from page 11 Nebulizer Administration" dated 8/31/22, indicated the facility will disconnect the T-piece, mouthpiece, and medication cup when the nebulizer treatment is complete, store the equipment in a plastic bag with the resident ' s name and the date on it, and change equipment and tubing per facility policy. Review of the clinical record indicated Resident R148 was admitted to the facility on 6/9/23. Review of the MDS dated 6/12/23, indicated diagnoses of pneumonia (severe inflammation of the lungs from an infection), respiratory failure (a serious condition where the lungs cannot get enough oxygen into the blood), and dependence on supplemental oxygen. Review of physician's orders dated 6/12/23, indicated a current order to titrate oxygen to maintain oxygen saturation (the amount of oxygen present in the blood) above 90%. Review of physician's orders dated 6/9/23,	F 0695		

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F 0695 SS=E	Continued from page 12 indicated a current order for ipratropium-albuterol nebulizer solution (an inhaled medication used to treat and prevent symptoms of wheezing, shortness of breath, and difficulty breathing) two times daily. Observation and interview of Resident R148 on 6/13/23, at 10:13 a.m. revealed the resident was receiving oxygen therapy at 3 liters per minute via a nasal cannula and the nebulizer machine was on the bedside table with the T-piece, mouthpiece, and medication cup assembled and sitting on top of the machine while not in use. Observation and interview of Resident R148 on 6/14/23, at 10:32 a.m. revealed the resident was receiving oxygen therapy at 3 liters per minute via a nasal cannula and the nebulizer machine was on the bedside table with the T-piece, mouthpiece, and medication cup assembled and sitting on top of the machine while not in use. Review of the clinical record failed to reveal a current order to change the oxygen tubing and the	F 0695		

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F 0695 SS=E	Continued from page 13 nebulizer equipment and tubing. During an interview on 6/15/23, at 12:28 p.m. Registered Nurse (RN) Employee E1 confirmed the nebulizer set up was assembled and not stored per facility policy while not in use. When asked how does staff know when to change the oxygen tubing and nebulizer set ups, RN Employee E1 stated, "there should be an order on the profile to change respiratory equipment. The admission nurse enters this order and the ADON does it if the admission nurse forgets." During an interview on 6/16/23, at 10:55 a.m. the ADON confirmed there was no order to change oxygen tubing and no order to change nebulizer equipment and tubing per facility policy. Review of the clinical record indicated Resident R152 was admitted to the facility on 6/3/23. Review of the MDS dated 6/13/23, indicated diagnoses of heart failure (a progressive heart	F 0695		

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F 0695 SS=E	Continued from page 14 disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dependence on supplemental oxygen. Review of physician's orders dated 6/9/23, indicated current orders to titrate oxygen to maintain oxygen saturation >90%. Review of physician's orders dated 6/3/23, indicated current orders for Albuterol (a medication that is inhaled to make breathing easier by relaxing the muscles in the lungs and widening the airway) inhalation every six hours as needed for wheezing. Review of physician's orders dated 6/14/23, indicated current orders for DuoNeb inhalation solution (an inhaled medication used to treat and prevent symptoms of wheezing, shortness of breath, and difficulty breathing) every four hours for three days for shortness of breath. Observation and interview of Resident R152 on	F 0695		

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F 0695 SS=E	Continued from page 15 6/12/23, at 11:29 a.m. revealed the resident was receiving oxygen therapy at 3 liters per minute via a nasal cannula. Observation and interview of Resident R152 on 6/15/23, at 12:24 p.m. revealed the resident was receiving oxygen therapy at 3 liters per minute via a nasal cannula and the nebulizer machine was sitting on the bedside table with the T-piece, mouthpiece, and medication cup assembled and sitting on top of the machine while not in use. Review of the clinical record failed to reveal a current order to change the oxygen tubing and the nebulizer equipment and tubing. During an interview on 6/15/23, at 12:26 p.m. RN Employee E1 confirmed the nebulizer set up was assembled and not stored per facility policy while not in use. During an interview on 6/16/23, at 11:03 a.m. the ADON confirmed there was no order to change	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395164	A. BLDG: __00_____ B. WING: _____	06/16/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. JOHN SPECIALTY CARE CTR	**P O BOX 928 500 WITTENBERG WAY MARS, PA 16046**
STATE LICENSE NUMBER: **970802**	

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F 0695 SS=E	Continued from page 16 oxygen tubing and no order to change nebulizer equipment and tubing per facility policy. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services 28 Pa. Code: 211.12(d)(3) Nursing services.	F 0695		
F 0812 SS=F		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 17 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All food in the kitchen was labeled and dated on 6/12/2023. All food that was not labeled and dated in the refrigerator on the unit was discarded on 6/16/2023. All expired food was discarded on 6/16/2023. Food stored under the sink was discarded. A temperature log was placed at the refrigerator on the unit. 2. Director of Nursing or designee will ensure that all refrigerators and freezers have temperature logs on them by 7/7/2023. Dietary Director purchased test strips and they were received on 7/12/2023 from ecolab. 3. Dietary Director of designee will educate employees on the proper labeling and dating of foods being stored by 7/14/2023. Dietary Director of designee will educate food service employees on the procedure for using test strips by 7/21/2023. Director of Nursing or designee will educate staff on documenting refrigerator and freezer temps. 4. Dietary Director or designee will audit food storage twice weekly beginning 7/1/2023. Dietary Director of designee will audit the use of the	Completion Date: **07/28/2023** Status: **APPROVED** Date: **07/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 18	F 0812	test strips on a daily basis beginning 7/11/2023. Director of Nursing or designee will audit refrigerator logs and food stored on the unit for proper storage and expirations weekly for 4 weeks and then monthly until substantial compliance is obtained. 5. Education and audits will be reviewed at the quarterly Quality Assurance and Performance Improvement meetings	

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F 0812 SS=F	Continued from page 19 Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly label and date food products, and verify the sanitizing temperature of the dish machine in the Main Kitchen (Main Kitchen), and properly monitor refrigerator temperatures, and properly store food products in one of three nursing unit pantries (Brookfield) and failed to properly date food and monitor food for expiration dates in three of three nursing unit pantries (Brookfield, Wellstep, and Creekside), which created the potential for food borne illness. Findings Include: Review of the facility policy "Food Storage: Sanitation and Infection Control" last reviewed 3/23/23, indicated that all products are labeled and dated with the receiving date. Review of the facility policy "Dishwashing and Pot Washing Procedures: Sanitation and Infection Control" last reviewed 3/23/23, indicated that	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 20 setting the right temperature for the commercial dishwasher is critical to ensure property sanitized cookware, dishes, and utensils to prevent foodborne illness. Dishwasher temperatures are maintained per manufacturer's guidelines and in accordance with nationally recognized standards of practice. Dish machine temperatures are checked and recorded before use for each meal cleanup period. Review of the facility policy "Food Brought into Resident's Room from Outside Sources" last reviewed 3/23/23, indicated that foods or beverages brought in from outside will be labeled with the resident ' s name and room number. Nursing will date the food with the date the item(s) was brought to the community for storage. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by nursing staff. Nursing staff will monitor resident's room, household pantry, and refrigeration units for food and beverage disposal. All refrigeration units will have internal thermometers to monitor temperatures. All units must be maintained at internal temperatures that are	F 0812		

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F 0812 SS=F	Continued from page 21 deemed safe for food storage. During an observation in the Main Kitchen walk-in refrigerator, on 6/12/23, at 9:55 a.m., a plastic wrapped package of meat was observed with no label or date. During an interview with the Food Service Director Employee E2 confirmed that the facility failed to properly label and date food products. During an observation in the Main Kitchen dish room, on 6/13/23, at 1:15 p.m. it was revealed that the facility does not verify the final rinse temperature of the dish machine by running a temperature test strip through the dish machine to verify the operating condition of the dish machine. During an interview on 6/13/23, at 1:32 p.m., the Food Service Director Employee E2 confirmed that the facility failed to make certain the final rinse temperature of the dish machine was operating properly to sanitize the equipment.	F 0812		

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F 0812 SS=F	Continued from page 22 During an observation on the Brookfield Nursing Unit Pantry on 6/16/23, at 10:10 a.m., the following was noted: -The small refrigerator contained a plastic container of salad with no date. -Refrigerator temperature log for the small refrigerator was absent. -A case of applesauce was stored underneath the sink. -Baskets of prepackaged snacks were stored without dates. -Three packages of Fig Newtons were found to be past the manufacture ' s expiration date of 6/12/23. During an interview on 6/16/23, at 10:20 a.m., Clinical Manager Registered Nurse Employee E3, and the Director of Nursing (DON) confirmed that the facility failed to properly date foods, monitor and record refrigerator temperatures, properly store food, and failed to dispose of expired food products.	F 0812		

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F 0812 SS=F	Continued from page 23 During an observation on the Wellstep Nursing Unit Pantry on 6/16/23, at 10:30 a.m., the following was noted: -Baskets of prepackaged snacks were stored without dates. -Four packages of sugar free cookies were found to be past the manufacture ' s expiration date of 6/1/23. During an interview on 6/16/23, at 10:42 a.m., the DON confirmed that the facility failed to properly date food and dispose of expired food products. During an observation on the Creekside Nursing Unit Pantry on 6/16/23, at 10:50 a.m., the following was noted: -Baskets of prepackaged snacks were stored without dates. -Six packages of sugar free cookies were found to be past the manufacturer ' s expiration dates of 6/1/23, and 6/15/23.	F 0812		

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F 0812 SS=F	Continued from page 24 During an interview on 6/16/23, at 10:54 a.m., the DON confirmed that the facility failed to properly date food and dispose of expired food products. 28 Pa. Code: 211.6 (c)(d)(f) Dietary Services.	F 0812		
F 0943 SS=D		F 0943		

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F 0943 SS=D	Continued from page 25 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	1. Employees E4 and E5 will complete all required trainings by 7/14/2023. 2. Staff education is assigned monthly to all staff to meet the trainings required for their positions. Staff educator or designee will audit trainings monthly to ensure timely completion. 3. The Clinical Educator or designee will audit employee training records. Staff out of compliance with education requirements will be required to complete the trainings no later than 7/14/2023 or will be removed from the schedule until completed. 4. Administrator or designee will educate managers on the importance of monitoring staff education by 7/7/2023. 5. Education and audits will be reviewed at the quarterly Quality Assurance and Performance Improvement meetings	Completion Date: **07/28/2023** Status: **APPROVED** Date: **07/11/2023**

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F 0943 SS=D	Continued from page 26 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on abuse and neglect prevention for two of ten staff members (Employees E4 and E5). Findings include: Review of the "Facility Assessment" dated 9/28/22, indicated facility staff will complete annual mandatory training on abuse, neglect, misappropriation, and exploitation. The facility "Abuse, Prevention of Abuse, Neglect, Mental Abuse, Reports of Theft, Exploitation and Misappropriation of Property" policy dated 8/31/22, indicated all employees are required to participate in mandatory annual educations relative to resident rights and training relating to abuse. Review of Nurse Aide (NA) Employee E4's education record indicated she was hired on 1/7/16.	F 0943		

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F 0943 SS=D	Continued from page 27 Review of NA Employee E4's training record for 1/7/22, through 1/7/23, did not include training on abuse and neglect. Review of Registered Nurse (RN) Employee E5's education record indicated she was hired on 2/26/19. Review of RN Employee E5's training record for 2/26/22, through 2/26/23, did not include training on abuse and neglect. During an interview on 6/14/23, at 2:37 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documentation of training for abuse and neglect prevention for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0943		

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F 0949 SS=B	483.95(i) Behavioral Health Training §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by:	F 0949	1. Employees E4 and E5 will complete all required trainings by 7/14/2023. 2. Staff education is assigned monthly to all staff to meet the trainings required for their positions. Staff educator or designee will audit trainings monthly to ensure timely completion. 3. The Clinical Educator or designee will audit employee training records. Staff out of compliance with education requirements will be required to complete the trainings no later than 7/14/2023 or will be removed from the schedule until completed. 4. Administrator or designee will educate managers on the importance of monitoring staff education by 7/7/2023. 5. Education and audits will be reviewed at the quarterly Quality Assurance and Performance Improvement meetings	Completion Date: **07/28/2023** Status: **APPROVED** Date: **07/11/2023**

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F 0949 SS=B	Continued from page 29 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on behavioral health and dementia for two of ten staff members (Employeees E4 and E5). Findings include: Review of the "Facility Assessment" dated 9/28/22, indicated all nursing staff will have training on Alzheimer's/Dementia/Cognitive Impairments. Review of Nurse Aide (NA) Employee E4's education record indicated she was hired on 1/7/16. Review of NA Employee E4's training record for 1/7/22, through 1/7/23, did not include training on behavioral health and dementia. Review of Registered Nurse (RN) Employee E5's education record indicated she was hired on 2/26/19. Review of RN Employee E5's training record for 2/26/22, through 2/26/23, did not include	F 0949		

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F 0949 SS=B	Continued from page 30 training on behavioral health and dementia. During an interview on 6/14/23, at 2:37 p.m. the Nursing Home Administrator confirmed that the facility failed to provide documentation of training on behavioral health and dementia for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0949		

Certified End Page

ST. JOHN SPECIALTY CARE CTR

STATE LICENSE NUMBER: 970802

SURVEY EXIT DATE: 06/16/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY